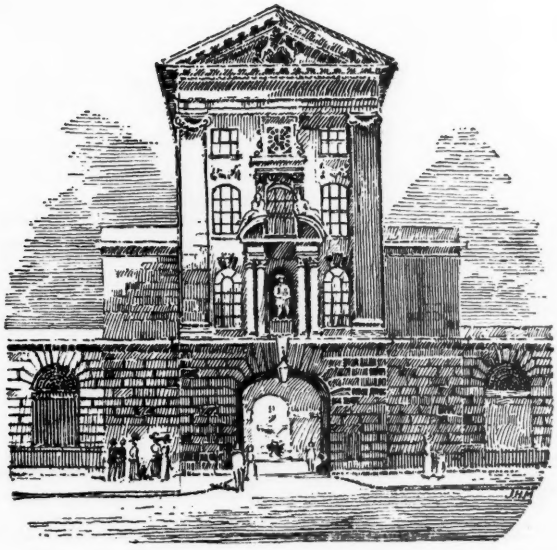
ST. BARTHOLOMEW'S HOSPITAL JOURNAL



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St. Bartholomew's Hospital

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

Journal.

VOL. XXXVIII.—No. 6.] MARCH 1ST, 1931. PRICE NINEPENCE.

CALENDAR.

Mon.,	Mar.	2.	—Special Subject: Clinical Lecture by Mr. Higgs.
Tues.,	,,	3.	—Prof. Fraser and Prof. Gask on duty.
Wed.,	,,	4.	—Surgery: Clinical Lecture by Sir C. Gordon-Watson. Hockey Match *v.* Staff College.
Fri.,	,,	6.	—Sir Percival Hartley and Sir Holburt Waring on duty. Medicine: Clinical Lecture by Dr. C. M. Hinds Howell.
Sat.,	,,	7.	—Rugby Match *v.* O.M.T.'s. Home. Association Match *v.* University College. Home. Hockey Match *v.* St. Lawrence College.
Mon.,	,,	9.	—Special Subject: Clinical Lecture by Mr. Bedford Russell.
Tues.,	,,	10.	—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Wed.,	,,	11.	—Surgery: Clinical Lecture by Mr. L. Bathe Rawling.
Fri.,	,,	13.	—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty.
Sat.,	,,	14.	—Rugby Match *v.* London Irish. Home. Association Match *v.* St. Thomas's Hospital. Home. Hockey Match *v.* Old Felstedians. Home.
Mon.,	,,	16.	—Special Subject: Clinical Lecture by Mr. Just.
Tues.,	,,	17.	—Dr. Gow and Mr. Harold Wilson on duty.
Thurs.,	,,	19.	—**Last day for receiving matter for the April issue of the Journal.**
Fri.,	,,	20.	—Prof. Fraser and Prof. Gask on duty.
Sat.,	,,	21.	—Rugby Match *v.* London Scottish. Home. Association Match *v.* Old Brentwoods. Home.
Tues.,	,,	24.	—Sir Percival Hartley and Sir Holburt Waring on duty.
Fri.,	,,	27.	—Sir Thomas Horder and Mr. L. Bathe Rawling on duty.
Sat.,	,,	28.	—Rugby Match *v.* Plymouth Albion. Away.
Mon.,	,,	30.	—Rugby Match *v.* St. Ives. Away.
Tues.,	,,	31.	—Dr. C. M. Hinds Howell and Sir C. Gordon-Watson on duty. Rugby Match *v.* Bristol. Away.

EDITORIAL.

JOHN ABERNETHY BROADCASTS.

Three years ago William Harvey might have been seen on "the silver screen" neatly experimenting in honour of his own *De Motu Cordis*. Daily, for some weeks past, has one of our penny contemporaries translated the stirring episodes of history into modern journalese. And now Dr. Abernethy has broadcasted. For a brief quarter of an hour those who wished might tap his consulting-room secrets, might hear him, bullying the rich for their gluttony and their pride, and the poor for their credulity and their gratitude.

So the newspaper paragraph, the cinema and the wireless, the three new sense-organs that the twentieth century has imposed upon us, play their part in popularizing history. The day of the private auscultation of history's heart-beats is gone; the giant phonendoscope, one chest-piece and a loud-speaker, is the modern mode. Though mildly we regret the change, yet we are glad that Abernethy was prevailed upon to broadcast. He came through the ordeal, slightly distorted, perhaps, but with credit, and it is comforting to know that, outside the school that he founded, his name has still, one hundred years after his death, for the world at large, a meaning.

* * *

MORE "BOOKS BY BART.'S MEN."

Sir Archibald Garrod has just published a new book, *The Inborn Factors in Disease* (Oxford University Press). In it he surveys the history of "diathesis" and discusses the underlying principles of predisposition. A review of this stimulating book will appear in a later issue.

In the present JOURNAL will be found reviews of Dr. Geoffrey Bourne's "broadly conceived and attractively written" *Introduction to Medical History and Case-taking*, and of Sir D'Arcy Power's *Selected Writings*. Rumour

has it that the Staff of the Hospital, active and consulting, is seething with literary activity, and several more books are to be expected shortly.

* * *

A REMARKABLE TRIBUTE TO SIR HOLBURT WARING.

The following paragraph, which appeared recently in a well-known weekly paper, seems to merit reprinting:

"Sir Holburt Waring, the famous surgeon of St. Bartholomew's Hospital, tells his students that no man should practise medicine without knowing what pain really means. His method of overcoming this handicap is probably unique. Every student who passes through his hands must submit to one of two tests: he must suffer without anæsthetic the removal of a toenail, or he must insert and remove a stomach tube.

"But no student who submits to these drastic tests of his courage may doubt the like quality in the famous examiner. Once Sir Holburt demonstrated his own attitude to physical suffering by removing his own appendix himself without anæsthetics!"

We have not been able to verify the truth of these statements.

* * *

ST. BARTHOLOMEW'S HOSPITAL ALPINE CLUB.

The second meeting of the Club was held at the Holborn Restaurant on Wednesday, February 11th, at 7.15 p.m. After an excellent dinner, the Chairman, Prof. Gask, reported on the proposed Whitsun expedition to the Snowdon district, whither the energetic Secretary, Mr. G. H. Bradshaw, had already penetrated to reserve hotel accommodation. Further details would be announced later. The company then proceeded to the serious business of the evening, to hear (and to see) an illustrated lecture by Dr. L. P. Garrod on climbing in the Tyrol, and to watch a series of Kodak Alpine films. The enthusiastic attendance at both of the meetings held so far must be most gratifying to the founders, with its promise of a long and successful career for the Club. After a few more dinners Everest itself will hold no terrors for the members.

* * *

EPSOM COLLEGE FOUNDATION.

The attention of all Bart.'s men who are Governors of Epsom College is called to the fact that the sons of two Bart.'s men are seeking election to Foundation Scholarships.

John Ridley Prentice is the eldest son of the late Dr. Hugh R. Prentice, who died in February, 1926, at the early age of 45. Educated at St. Bartholomew's, Dr. Prentice devoted himself particularly to neurology, and after being R.M.O. at the National Hospital, was elected to the staff of the Dreadnought Hospital, the West End Hospital for Nervous Diseases and the Belgrave Hospital. During the war he held a commission in the Royal Navy.

Hugh Frederick Steele-Smith is the son of W. Steele-Smith, who was educated at Bristol and St. Bartholomew's, and after being in practice in Kent and in Manchester was compelled to give up in 1916 owing to ill-health.

* * *

TENTH DECENNIAL CLUB.

The Tenth Decennial Club Dinner will be held as usual on the second Friday in May, *i. e.* May 8th. Dr. C. N. Binney will be in the Chair. Notices giving further details will be circulated later. Secretaries: Mr. Reginald M. Vick, Dr. Arnold W. Stott.

* * *

BUSY BEES.

The Bart.'s Busy Bees held their annual Christmas Party in the Great Hall on Wednesday, January 14th. It was attended by nearly 300 Bees, and the Committee's thanks for its enormous success are particularly due to Mr. Vick for a delightful talk, Mr. Patrick Playfair for his conjuring, and to all the ladies who gave their help and time. A financial report will be found in *Beeswax*—the Bees' journal, published in May.

* * *

Prof. F. R. Fraser will deliver a lecture on "The Hospital: Its Place in the Medical Curriculum," before the Cambridge University Medical Society, on Wednesday, March 11th.

* * *

"B.M.A." ADDRESS.

Dr. Hector Charles Cameron, M.D., F.R.C.P., will deliver an address on "Children in Hospital and in the Home: A Contrast," at the British Medical Association House, Tavistock Square, on Tuesday, March 10th, 1931, at 5.30 p.m. The lecture is intended for those soon to be and those recently qualified.

* * *

Sir George Newman, K.C.B., M.D., F.R.C.P., D.P.H., has been appointed a Fellow of King's College, London.

* * *

The Julius Mickle Fellowship for 1931 has been awarded to Dr. C. H. Andrewes, M.B., B.S., M.D.

* * *

Dr. A. A. Miles and Dr. E. T. C. Spooner have been appointed University Demonstrators in Pathology at Cambridge.

* * *

Congratulations to the Rubgy XV on their victory over Guy's, a stirring account of which appears on p. 124.

STOP PRESS.—Bart.'s *v.* King's, 16—3. Good luck on March 18th.

AVERTIN.

A REPORT OF 170 CASES.

"Sleep that knits up the ravelled sleave of care,
The death of each day's life, sore labour's bath,
Balm of hurt minds."—*Macbeth*, Act II, Scene 2.

IN olden days the Elixir of Life gilded the dreams of alchemist and physician alike; nowadays the physician thinks in terms of ductless glands, and the scientist dwells upon the meaning of reality. And yet each one strives to wrest secrets from Nature for the good of humanity and the advancement of knowledge. Time alone sifts these discoveries, and eventually those things which were hailed as perfect are relegated to their proper realm, and each has its appointed place. So with avertin: the drug was originally recommended as a substitute for inhalation anæsthesia; it was said to prevent vomiting entirely, and to be that perfect anæsthetic that all anæsthetists desire and yet so far have not obtained. It is no longer attempted to obtain full anæsthesia with avertin, but a deep sleep is aimed at which renders nitrous oxide oxygen an adequate adjuvant to produce satisfactory anæsthesia. With regard to vomiting, one can almost guarantee absence of this distressing occurrence if gas oxygen only is used, but if ether has to be added to produce full relaxation then the risk of sickness increases with the amount of ether inhaled.

Patients fear the anæsthetic more than anything else, and their apprehension is due to a horror of suffocation This fear on the part of the patient can be banished entirely by the use of avertin, the patient just falling asleep in her own bed amidst familiar surroundings, and waking up as from a normal sleep.

PREPARATION AND METHOD OF USE.

Tribromethyl alcohol is a white crystalline solid, soluble in water with difficulty. It is sold commercially in liquid form dissolved in amylene hydrate, 1 c.c. of the fluid being equivalent to 1 grm. of solid avertin. Heat causes decomposition to hydrobromic acid and dibromacetaldehyde. Both these substances are very irritant, so that care must be exercised in the preparation The manufacturers quite rightly emphasize this risk of decomposition, and one felt at first that this was a very serious drawback to the use of the drug. However, the writer has carried out tests, and found that only after repeated boiling did hydrobromic acid make its appearance. The required dose of avertin is added to distilled water sufficient to make a 3% solution. The distilled water should be warmed to 100–105° F. before adding the avertin, and into this should be dropped sufficient Congo red 1 in 1000 to make the fluid just faintly pink. This latter is added as an indicator, the solution turning blue if hydrobromic acid is formed. If the distilled water be not warmed first the avertin will separate out, and then much shaking will be necessary to obtain complete solution. The preparation does not really take more than five minutes.

DOSAGE.

This is based on the patient's body-weight, and experience is necessary in this matter, for other factors enter in as well. Elderly and feeble patients require less, and children need relatively more. There seems to be a minimal effective dose, so that the less the patient weighs the more avertin per kg. body-weight is required. For instance, a child of 3 st. in weight will need 0·1 grm. avertin per kg. body-weight, whereas an adult of 16 st. will require only ·07 to ·08 grm. per kg.

For general use the writer recommends a dose of ·08 grm. per kg., and for those patients with hyperthyroidism 0·1 to 0·11 grm. per kg.

Morphine $\frac{1}{6}$ gr. is given $1\frac{1}{4}$ hours before operation, and the avertin fluid in solution is run in *per rectum* one hour before operation.

Children are not given any preliminary morphine, and the dose of avertin used is 0·1 grm. per kg. body-weight, and is given at least half an hour before coming to the theatre.

PREPARATION AND POSITION OF PATIENT.

It is preferable to give an enema the night before operation, but this is by no means absolutely necessary. If the rectum be full, absorption is slow, and the drug may fail to act. Glucose by mouth is recommended during the 24 hours preceding operation.

The patient is placed on her left side with the buttocks well raised so as to encourage the fluid to run well up the bowel. It is at this stage that the patient should be relieved of any dentures! The solution is run in through an ordinary rubber catheter with funnel attached, and usually the avertin can be allowed to enter quite quickly, as the bulk seldom exceeds 200 c.c. One need not spend more than five minutes over this procedure, and the patient is usually asleep within ten minutes. Speech gets thicker and thicker, and sleep comes quite suddenly. The patient should not be disturbed now for half an hour, when a small hypodermic dose (gr. $\frac{1}{150}$) of atropine may be given.

The appearance of the patient at this stage resembles

normal sleep. Respiration is easy and quiet, there is no cyanosis, and the pupil is pin-point whether morphia has been given or not. The corneal reflex is sometimes absent, or very sluggish.

Cyanosis is due to imperfect airway or overdose. It need hardly be stressed that the patient should never be left, for there is a remote possibility that the tongue may slip back and obstruct the airway.

Choice of Anæsthetic.

Nitrous oxide and oxygen suffices for everything except upper abdominal operations; and the oxygen percentage is not critical. Anæsthesia can be maintained with ease, and no cyanosis should be allowed. As respiration is sometimes rather depressed carbon dioxide is recommended for stimulation of the respiratory centre, so as to enable sufficient ether to be absorbed to obtain relaxation. Local infiltration of the abdominal wall proves a most satisfactory combination. Spinal anæsthesia should be used with extreme caution.

Indications.

For the very nervous individual, be he child or adult, avertin and nitrous oxide oxygen offer an almost ideal combination. Post-operative excitement is very rare indeed.

Avertin is indicated particularly in patients who are known to be very sick after anæsthetics. It is pathetic to see how grateful such patients are who have avertin under these circumstances, and not a little gratifying to the anæsthetist for the extra time and trouble taken. With nervous children particularly avertin is at its best, for they frequently awaken loudly demanding food!

Contra-Indications.

As avertin is excreted by the kidney it is contra-indicated in severe renal disease, and there is some evidence of its having a toxic action upon the liver, so that it should not be used where liver damage is suspected.

Hæmorrhoids and *fissure in ano* are no bar to the use of avertin, but when operations are to be performed on the rectum or anus it is necessary to wash out the lower bowel immediately prior to the commencement of the operation.

Duration of Post-Operative Sleep.

This is very variable. It depends largely upon the dose used. Usually the patient sleeps for some 3 hours after operation, and memory returns to the patient one hour after this. The patient may apparently be fully round and talk quite intelligently, and yet remember nothing of this conversation a few hours later. Some patients come round almost immediately, and others sleep for 5 or 6 hours.

Failures.

"Sleep that cometh to all came not to him."

Some five or six cases of this series have not been asleep on coming to the theatre. In two, certainly, the dosage was on the small side. In two others the rectum was loaded with fæces. Four of them did not remember coming to the theatre.

Complications.

In another country death has followed the use of avertin, but this was due to the attempt to obtain full surgical anæsthesia. Given in the small doses as used now, the writer feels confident that no trouble will ensue, provided the preliminary use of morphine is cut down to a minimum. The writer has had one death in this series; this was a patient who had been given avertin in combination with a high spinal anæsthetic. She collapsed and died some eight hours after a long and very difficult exploration of the gall-bladder region. Pulmonary complications have been markedly absent, except in the case of one man who was definitely a bronchitic, and he had a slight attack of bronchitis following his operation.

Post-Operative Excitement.

One patient was really violent afterwards for about a quarter of an hour. He was a man who had had his sciatic nerve stretched. It was his second dose of avertin within eight days, and yet after the first dose (injection of sciatic nerve with normal saline) he was quite normal. After the injection of morphine he soon became quiet.

	Vomit once or twice.	Vomit more than twice.	No vomit at all.
Total cases . . . 170	45 (26·5%)	12 (7%)	113 (66·5%)
Cases where nitrous oxide and oxygen only was used 100	17	6	77
Cases where ether was used as well in greater or lesser amount (*i. e.* upper abdominals, excluding gastrostomies and appendicectomies) . . . 25	7 (28%)	2 (8%)	16 (64%)

Total.		Vomit once or twice.	Vomit more than twice.	No vomi at all.
Breasts	20	6 (30%)	2 (10%)	12 (60%)
Appendices	18	8	1	9
Hernias	21	1	1	19
Gastrostomies	7	1	0	6
Thyroids	23	5	4	14
Upper abdomen*	25	7 (28%)	2 (8%)	16 (64%)

These results tend to demonstrate that the addition of ether causes a rise in the incidence of vomiting. The presence of blood in the stomach after gastro-enterostomy is apt to precipitate sickness, but on comparing the results of gastro-enterostomy with those obtained with cholecystectomy it would appear that the presence of blood in the stomach as a cause of vomiting is negligible, as compared with the stimulation of the sympathetic by traction on and around the gall-bladder, and by the fact that more ether is required to maintain relaxation under these circumstances. The figures are self-explanatory, and the writer ventures to suggest that the results show that avertin definitely decreases the amount of after-sickness. He finds that patients are now demanding this drug and are most enthusiastic about it. There is no difficulty in using it as a routine in hospital, thanks to the active co-operation of the nursing staff involved.

CONCLUSIONS.

1. Avertin is a great advance, and in proper dosage is quite safe.

2. The dosage recommended ·08 grm. per kg. body-weight, with preliminary morphine $\frac{1}{6}$ grm., or ·1 grm. per kg. body-weight if no morphine used.

3. Nitrous oxide oxygen is necessary to complete the anæsthesia.

4. The likelihood of vomiting depends largely on the amount of ether used.

5. Vomiting is absent in most patients: its absence can almost be guaranteed if nitrous oxide oxygen only be used.

6. It is strongly recommended for the patient who has a history of being very sick after ordinary anæsthesia, and for the highly nervous individual.

The writer has attempted to give in the foregoing some description of the technique of avertin administration, and to put on record the results as accurately as possible. It seems that with avertin the patient is sick only once or twice, if at all, whereas with ordinary general anæsthesia the patient is much more uncomfortable and vomits more frequently. Patients are now asking for avertin after once having had it.

Truly "The old order changeth, yielding place to new."

* Cholecystectomies, gastro-enterostomies and gastrectomies, excluding gastrostomies. Of these 6 were combined spinal percain and avertin. 3 were sick and 3 were not. (One died some hours later of collapse.)

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FRANKIS T. EVANS.

VARICOSE VEINS: THE CONTRA-INDICATIONS TO INJECTION TREATMENT.

DURING the course of the past few years injection treatment of varicose veins has entirely replaced operative measures. Yet the very success and simplicity of the new method have brought with them the danger of over-enthusiasm. It is under these circumstances that one is at times confronted with an attitude of mind on the part of the medical adviser which may be briefly summed up—"Here's a varicose vein, let's inject it!" When it is remembered that approximately 10% of all varicose vein cases presenting themselves for treatment have conditions which either temporarily or permanently render them entirely unsuitable subjects for injection therapy, it is obvious that such an uncritical outlook can only bring discredit on an established and valuable method of treatment.

In every case where injection treatment is contemplated a detailed case-history must always be taken, and the information gained from this will, as a general rule, enable the surgeon to eliminate many of the unsuitable cases. As regards the clinical examination, this should always be a complete one in every case where the history suggests that the varicose condition may be the result of some previous disease or associated

with some serious systemic disease. The points of special importance in the history and in the clinical examination are more fully discussed later.

If, on the other hand, varicose veins are treated as mere trivialities and ordinary clinical care disregarded, then unsuitable cases are bound to be given injections, with the result that patients are made worse by treatment or are subjected to grave risks.

The present article in no way discusses the question of the merits or demerits of the various solutions in current use for bringing about thrombosis, and the contra-indications mentioned are contra-indications to all forms of injection treatment. These are discussed under the following headings:

A. Permanent contra-indications.
B. Temporary contra-indications.
C. Conditions where caution is necessary.

A. Permanent Contra-indications.

In the majority of cases varicose veins are primary or idiopathic, but in a certain proportion of cases they are secondary or compensatory, and develop as the result of obstruction of the deep veins of the limb. It is to this latter group of cases that attention is especially directed here.

The deep veins of the lower limb may become thrombosed from a variety of causes, the most important being white leg, typhoid fever, and as a post-operative complication. No matter in which of these ways the obstruction of the deep veins is brought about, the onset of the condition is associated with pain in the limb, a variable degree of swelling and œdema of the foot, leg, and possibly lower part of the thigh. In the course of time the acute symptoms subside, but for years, or even permanently, the affected limb is larger than its fellow, is painful and weak, and tends to increase in size from œdema towards the end of the day.

At the same time a collateral venous circulation is established to help in getting rid of the blood from the deeper parts of the limb. This collateral circulation may be in deeper veins which are not thrombosed, or it may be in the superficial veins of the limb, which then often become varicose as the result of the extra work thrown upon them. The femoral veins in such cases being impervious, the superficial varicose veins have to run above Poupart's ligament before they can anastomose with veins of the trunk. It is not unusual under these circumstances to find a varicose condition of the superficial circumflex iliac, the superficial epigastric, or the superficial external pudic veins, with the blood-flow passing in a reverse direction to the normal. For example, in a patient recently seen who had had deep thrombosis of both legs following appendicectomy, the varicose internal saphenous veins of both limbs drained directly into varicose superficial epigastric veins which reached as high as the fourth intercostal spaces.

In cases such as these where the history is suggestive of a thrombosis in the deep veins, or where dilated veins are present above Poupart's ligament, or where œdema is present in the foot or leg, injections are absolutely and permanently contra-indicated. The varicose process must be recognized as a compensatory one, and any interference with it by obstructing superficial venous channels is only likely further seriously to incommode a severely damaged circulation which is doing its best to carry on. Should injections be given in these cases, the pain and œdema are almost certain to be increased, and at worst may lead to actual gangrene of the limb.

On rare occasions patients are seen where the history of deep thrombosis appears certain, but where no physical signs of a damaged circulation can be made out on examination. Such cases are wisely left alone, and in no case should treatment be considered without seeking a second opinion.

1. *White leg.*—In practice this is by far the commonest permanent contra-indication to injection treatment, and in every female patient the question of pregnancies and their complications should be elicited fully in the history. The onset of the condition may occur during the first few days after labour, or it may be delayed for ten or fourteen days, till the time the patient is beginning to get about again. The term itself is usually understood by the majority of women.

2. *Typhoid fever.*—The typhoid group of infections is not a common one, but it is in practice rather surprising to find the number of patients of the older generation who have had the disease at some time or another. Both arterial and venous thrombi may occur either during the active stage of the disease or during convalescence, and the complications are ones which must always be borne in mind.

3. *Post-operative thrombosis.*—Though this may follow any surgical procedure, it is most often seen after abdominal operations. In its symptomatology and clinical course it does not differ from the other types described.

4. *Subacute phlebitis involving superficial and deep veins.*—This condition differs from the preceding in that the main vein of the limb is not obstructed, but there is a localized thrombosis of both superficial and deep veins. From the point of view of the patient the history is usually one of long-standing varicose veins, which at some time or other began to get very painful, hard and swollen in a localized area. The symptoms persist, and the area of their extent gradually increases. Clinical examination reveals palpable thrombosed veins

over a certain area, usually the lower part of the calf, with a variable degree of brawny œdema of the tissues around, the whole region being definitely but not acutely tender, and in most instances well demarcated from the adjacent healthy tissues. The underlying pathological change in such cases is a mild phlebitis which never entirely undergoes resolution, but gradually leads to the thrombosis of the superficial and deep communicating veins in a given area of the limb. Where this condition is present, treatment of non-thrombosed veins by injections either leads to no improvement in the condition, or may actually aggravate the symptoms.

B. Temporary Contra-indications.

1. *Acute phlebitis.*—This may follow trauma, or it may occur spontaneously as the result of a low-grade infection. In practice it is quite impossible to say how far these two elements are determining factors in any given case. Hence all cases of phlebitis of the superficial veins must, therefore, be regarded as having an actual or potential infective element. Injection treatment during the course of phlebitis will thus merely add fuel to the flames, and as infected clots are softer and much more liable to detachment than those occurring after therapeutic thrombosis, embolic accidents may occur. It is certain that some of the recorded cases of pulmonary emboli which have occurred after injection treatment have arisen through injections having been given soon after an attack of phlebitis.

If the rule of always allowing an interval of at least six months to elapse after the subsidence of the acute symptoms of the phlebitis before carrying out injections is strictly adhered to, such risks are avoided. Even if the varicosities are bilateral and the phlebitis unilateral, it is unwise to treat the apparently healthy limb until this interval has elapsed.

Patients are occasionally seen who give a history of recurrent attacks of phlebitis every few months. Before considering the question of injection all possible causes of focal sepsis must be sought and eradicated. In some cases the frequency of the attacks of phlebitis is such that injection treatment should never be given. For example, a young woman referred to the writer for treatment gave a history of eleven attacks of phlebitis in the lower limbs and four in the upper limbs. During the course of two of these attacks she had had symptoms and signs indicative of small pulmonary emboli. In addition to the above there had also been a bilateral white leg following the birth of a child. Excluding for the moment the latter complication, which entirely contra-indicated any form of injection treatment, to give injections to a patient of this type would be to incur grave risks. Such patients should be regarded as thrombus and embolus factories and avoided like the plague!

2. *Pregnancy.*—In general the injection treatment of varicose veins during pregnancy is not recommended, but it should be delayed until this is terminated, when the veins are smaller and much more easily dealt with. When, however, veins are causing definite hardship to the patient and rendering life a misery, some of them may be justifiably treated, but quinine must not be used.

3. *Sepsis.*—The ordinary complications such as varicose dermatitis and ulcer are not included here, but local infective processes such as furuncles, etc., in the area adjacent to the veins are intended. Whenever these latter are present, injections should be delayed until all infection has resolved.

C. Conditions where Caution is Necessary.

1. *Cardiac disease.*—There is no reason why cases of compensated cardiac disease should be denied treatment, and in practice they respond normally. On the other hand, if there are any indications of failing compensation, injection must on no account be carried out.

2. *High blood-pressure.*—Other things being equal, a considerable increase in blood-pressure does not contra-indicate treatment. Varicose veins may at times give rise to symptoms indistinguishable from those of intermittent claudication, and in several cases of this type where varicose veins were associated with blood-pressures over 200 mm. Hg. the cure of the veins led to the relief of the symptoms.

3. *Renal disease.*—Provided no signs of renal failure are present treatment is not contra-indicated.

4. *Diabetes.*—This disease does not contra-indicate treatment, but in carrying it out the most stringent precautions to prevent anything in the nature of sepsis must be adopted.

5. *Age.*—Advanced age alone is no contra-indication to injection. The only questions to be considered are the degree of activity of which the patient is capable, the extent of the symptoms referable to the veins, and the amount of improvement likely to arise from their cure.

Summary.

1. A certain proportion of patients with varicose veins are either permanently or temporarily unsuitable subjects for injection treatment, and the carrying out of injections in such patients may lead to serious complications.

2. These cases may readily be eliminated by careful history-taking and thorough clinical examination.

3. In taking the history of varicose vein patients, special importance is attached to the occurrence of white-leg, typhoid fever, post-operative thrombosis, phlebitis in all its forms, and, of course, serious systemic diseases.

4. In carrying out the clinical examination the discovery of any of the following should put one on one's guard—local or general œdema of one or both legs, evidence of active or recent phlebitis, and the presence of varicose veins above Poupart's ligament.

5. Finally it may be pointed out that uncomplicated varicose veins never cause any œdema. Only in the presence of dermatitis, ulceration, phlebitis, periostitis or deep thrombosis does œdema arise secondarily.

REGINALD T. PAYNE.

A TREATMENT OF MIGRAINE.

MIGRAINE is a common malady. Its ætiology is little understood, and its treatment has so far been unsatisfactory.

There is a definite migraine diathesis which is met with in several members of successive generations of the same family. It is a notable fact that sufferers from migraine are alert, intelligent people, and are commonly professional men and women. The disease remains with them from early childhood through adolescence, until old age sometimes brings relief. It occurs with equal frequency in both sexes.

Nothing incapacitates so completely as this distressing hemicrania. Sufferers seek relief in dieting, they visit specialists, are tested for defects of vision and the vast majority get little relief.

Recently Hurst has stated that the chemical constitution of the body-fluids is not exactly the same in all healthy individuals. He believes that the slight variations from the normal form the basis of the congenital and often the inherited tendency to develop certain diseases. He considers that the asthma diathesis is caused by a slight permanent deviation from the normal blood chemistry, resulting in a disturbed balance of the "vagal-sympathetic-bronchial" nervous system. Many authorities place asthma, epilepsy and migraine in the same category because of their symptomatic similarities.

All sufferers can trace their migraine to early infancy. Frequent unaccountable bilious attacks can be remembered. The migraine childhood is punctuated by paroxysmal metabolic disturbances with violent headache, which is relieved only by acid release phenomena. The vomit and urine at the height of an attack are highly acid. Ketonuria and dyspnœa also occur. When sufficient acid has been eliminated the patient recovers but still remains the so-called acidosis patient and awaits the next attack. This cyclical vomiting slowly changes through adolescence to the adult migraine.

Migraine is due, in my opinion, to an inborn error of metabolism. There is a state of chronic metabolic disturbance causing an increased hydrogen ion content of the blood, with the subsequent permanent slight reduction of the sodium bicarbonate alkali reserve. It is known that acidosis causes a reduction of available calcium, which results always in an excitability of the nervous system.

Nervous excitability due to hypocalcæmia is well demonstrated in the convulsions of rickets and the spasmophilia of tetany. Migraine occurs in chronic nephritis as a symptom of uræmia where acidosis and hypocalcæmia are known to be present. It is certain that the acidosis effect on the alkali reserve is accumulative, and that the periodic attacks are an effort of Nature to relieve the excessive acid. Occasionally the attack is determined by some factor that further upsets this disturbed metabolism, such as a dietetic error or physical or nervous fatigue.

Asthma is due to nervous excitability affecting the vagal-sympathetic control of the bronchial tubes. Migraine is due to nervous excitability especially selecting the cervical sympathetic plexus.

The cervical sympathetic trunk is closely connected with the cœliac plexus and the vagus nerves. It joins with the cervical nerves to supply the sensory branches over the neck and shoulders. Fibres pass along the carotid arteries to act as vaso-constrictors. Certain other fibres pass along the internal carotid artery to reach the Gasserian ganglion, passing through to the ophthalmic division of the fifth nerve. These latter fibres are excitatory to the fifth nerve as a whole and to the ophthalmic branch in particular. The intense ophthalmic pain in migraine is due to the stimulation of these sensory fibres.

According to my experience the typical migraine attack may be divided into three stages:

Stage I.—The patient retires to bed with a feeling of fatigue, sleeps heavily, and wakes with the knowledge of an impending headache. The sympathetic nervous system is profoundly affected. He feels limp and languid, his blood-pressure and temperature are low. His face is pale and sometimes sweating. Anorexia and a vague throbbing at the back of the eyeball announce the onset of an attack.

As the morning progresses the cervical sympathetic

excitation causes spasm of the internal carotid and its branches. These comprise the retinal and facial arteries, the terminal branches to the frontal lobes, and the Rolandic and speech centres. Intellectual activity is arrested. Paræsthesias, hemi- and monoplegias and aphasia may occur.

Examination by the ophthalmoscope shows the retinal arteries to be in a state of spasm. Vaso-constrictor fibres can be traced to these small arteries which do not anastomose with each other. This lack of anastomosis causes an absolute loss of nutrition to groups of retinal cells during this stage. All degrees of visual disturbances may thus occur, from general mistiness, scotomata and hemianopia to complete blindness. Visual recovery is always complete at the end of stage II.

There is also intense ophthalmic pain, with dilatation of the pupil and retraction of the upper lid, accompanied by increased ocular tension and photophobia. It requires a conscious effort on the part of the patient to close the eye, and the orbicularis palpebrarum may even be in a state of spasm. The pain becomes a hemicrania due to involvement of the rest of the fifth nerve, and may extend through the cervical plexus over the neck and shoulder.

Stage II.—After hours have been passed in a state of psychological and physical collapse the vagus comes into action, and the excessive acid is disposed of by vomiting.

The kidneys excrete highly acid urine and the patient drops into a deep sleep. That there is a close connection between the ophthalmic sensory system and the vomiting centre is well shown in acute glaucoma.

Stage III.—The arterial spasm is released and the whole carotid system is engorged with blood. This is analogous to the venous congestion seen in Raynaud's disease when the initial arterial spasm passes off.

A study of the anatomy of the cavernous sinus explains the ophthalmoplegia which sometimes follows migraine. The cavernous sinus becomes engorged with blood, and compresses the cranial nerves found on its outer margin. The third, fourth and sixth nerves lie between the sinus and its firm outer covering of dura mater. Diplopia and strabismus may result, but recovery always occurs. In thrombosis of the cavernous sinus these nerves are often permanently affected. The following day finds the patient recovered but still asthenic.

Many variations of migraine may occur. The headaches may be bilateral. Minor attacks occur without vomiting or headache, causing slight visual disturbance and transient motor or sensory phenomena. The attacks may be at two or three days' interval, at week-ends, several months apart, or continuous, since the degree of acidosis varies with the individual patient.

TREATMENT.

It is necessary to give sodium bicarbonate and calcium to correct the disturbed metabolism. This is given in tablet or cachet form early in the morning. No food should be taken for an hour afterwards in order to prevent any saponification of calcium.

℞ Calcium lactate . . . . gr. x
Sodium bicarbonate . . . gr. x
Fiat cachet.

Two cachets should be taken daily for three months, and thereafter one cachet daily.

The following cases have been taken from a series I have treated by this method during the last three years:

CASE 1.—Mrs. S—, æt. 54. Bilious attacks in childhood. Migraine in adult life aggravated by menopause at 47. Typical migraine at four-weekly intervals with involvement of the speech centre. During the attacks she was incapacitated for two days. Between attacks she also suffered from morning headaches and anorexia with sickness every two or three days. A nervous, intelligent patient who had had various investigations and courses of treatment without relief. Started cachets in January, 1929, and has had no migraine since.

CASE 2.—Mr. P—, æt. 50; organ builder. Cyclical vomiting in childhood. Severe migraine since adolescence. His attacks were left-sided, with aphasia and right hemi-paresis. Often in a state of coma for hours. On one occasion he was severely burnt on the leg through slipping in the fire during coma. He had no knowledge of this accident until afterwards. Daily morning headaches with anorexia. Commenced treatment two years ago. No migraine or headaches since. He has gained 16 lb. in weight.

CASE 3.—Miss F—, æt. 45; magistrate. Bilious vomiting in childhood, followed by migraine in adult life. Severe attacks lasting two days. Completely incapacitated. Attacks occurred at 4–6 weeks' interval. No migraine for two years.

CASE 4.—Mrs. C—, æt. 40. Bilious attacks in childhood followed by migraine in adult life. Severe attacks lasting two days at four weeks' interval. This patient has had numerous investigations and rigid dieting. No migraine for two years.

CASE 5.—Master S—, æt. 7. Cyclical vomiting at 6 weeks' interval with collapse, and ketonuria. A nervous child of the negative type. One cachet each morning has relieved him for 12 months.

In conclusion, migraine is due to a congenital and often inherited error of metabolism, causing a permanent slight acidosis with a resultant diminution of the alkali blood reserve and blood calcium. This acidosis effect

is accumulative, causing a paroxysmal excitability of the sympathetic nervous system especially involving the cervical plexus. This condition may be corrected by the addition of sodium bicarbonate and calcium lactate to the daily menu.

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RICHARD W. TAYLOR.

SQUAMOUS-CELL CARCINOMA OF THE RENAL PELVIS.

SQUAMOUS-CELL carcinoma is stated to be the rarest of all types of malignant growths of the renal pelvis. As far as can be ascertained only three have been reported from this Hospital; all of these were reported by Mr. Geoffrey Keynes in 1924; up to that time only 60 cases appeared in the literature on this subject. Since then 6 more cases have been recorded, five by Scholl and Foulds from the Mayo Clinic, and one by J. A. Bowen and G. A. Bennett, of the Peter Bent Brigham Hospital, Boston. This brings up the number of cases to 65.

There has been considerable discussion as to their mode of origin, but nearly all authorities agree that it is the result of some localized chronic irritation.

In the literature numerous cases have been ascribed to long-standing renal calculi, but Miller and Herbst have shown that of 54 cases examined 10 only can be attributed to renal calculi. Mock, on the other hand, quotes 14·8% as the true figure for the presence of stone, whilst Albarran puts it as low as 6·2%. It is necessary, therefore, to look for some other predisposing cause.

Numerous writers have suggested long-standing infection as a possible cause. Cumming has shown that the normal transitional epithelium can become replaced by a many-layered coating of stratified squamous epithelium with superficial keratinization. This condition, leukoplakia, he states, is associated with infection, stone, and hydronephrosis. Other writers suggest that leukoplakia is a definite forerunner of the squamous-cell carcinoma of the renal pelvis. It seems possible that the condition as described by Cumming might easily be a stage immediately previous to that of malignant change.

It follows that the three associated conditions, namely infection, stone and hydronephrosis, must also be taken into consideration. This view is further strengthened by the fact that in the majority of cases bacterial infection was present in some form or other. Hydronephrosis, however, was not so common.

Miller and Herbst state that growths of the renal pelvis are common amongst aniline and chemical workers, such growths being usually transitional-celled papilloma or carcinoma arising from such papilloma.

The most constant symptom is that of painless hæmaturia, and it may be present for a considerable time before any pain is felt.

Prognosis is extremely bad in all cases; the patients rarely live more than six months after operation.

Distant metastases are common in the majority of cases, and show the same structure (Schmorl).

Mrs. J. S—, a pallid woman, æt. 59, boarding-house keeper, was admitted to St. Bartholomew's Hospital on September 30th, 1930. She gave the following history:

In February, 1902, she was operated on by Sir Holburt Waring for dermoid cyst of the left ovary. At operation the cyst was found to contain hair and sebaceous material. The pedicle was transfixed and the cyst removed. It was further noticed that the cyst was pressing on the left ureter and that a left hydronephrosis was present. This was reduced by pressure with the hand. Patient made an uninterrupted recovery.

In 1920 she noticed a lump the size of an egg in the left loin. It gave her no pain or discomfort. In 1925 her urine began to give her trouble. Her urine was pale, scanty, very thick and smelt badly. The lump in her loin was larger, but it still gave her no pain or discomfort. Her frequency at this time was D/N = 4/5–6. The condition then had continued, the lump had gradually grown larger, until in August, 1930, she began to feel ill. There was no change in her urine. Her frequency was now D/N = 2–3/3–6. There was no vomiting or nausea, but there was a loss of weight and of appetite. She felt weak and tired, and above all she had in her left loin a dull aching pain which did not radiate downwards. Her periods, which had been normal, ceased at the age of 40. There was no discharge at any time.

Condition on Examination.

Abdomen.—Left paramedian subumbilical scar present and sound. The abdomen was full in the left loin and left hypogastrium. On palpation there was a smooth tense tumour. It had deep, rounded margins. Edges were well defined but the contours were not quite regular. It was egg-shaped and measured 7 in. by 5 in. Fluctuation was present. It was tender, and was only just moveable in all directions. It did not arise from the pelvis, and it could be pushed into the loin and palpated bimanually. The long axis pointed downwards and inwards from the loin. It was dull to percussion.

Urine.—Thick and whitish; yellow deposit; foul odour; acid. Sp. gr. 1017; albumen + +. Blood and pus microscopically.

On September 16th, 1930, an operation for drainage of a pyonephrosis was performed by Mr. Geoffrey Keynes. A large amount of thick, flocculent, foul-smelling pus was withdrawn.

After operation.—A hard mass was palpated on the left side. It was irregular in shape, the surface was nodular, and it had well-defined edges and was moveable. It was 5 in. by 4 in. in size. An X-ray examination showed that there was an enormous branched, laminated calculus lying in the left loin.

A second operation for nephrectomy was performed by Mr. Geoffrey Keynes on October 24th, 1930. This, however, proved to be impossible owing to the numerous adhesions of the kidney to the surrounding structures. Instead, the calculus, weighing 93 grm., was removed. After the operation the patient made a good recovery until November 13th, when she complained of incontinence of urine and of fæces. This condition gradually grew worse and she died on November 23rd. During the later stages wasting was very apparent.

Post-Mortem Examination.

On November 24th a post-mortem examination was made, the report being as follows: Body of an extremely emaciated woman. Scar of oblique lumbar incision on left side. Healed except at lower end.

Congestion of both bases of lungs. No secondary deposits in the pleuræ.

Peritoneum.—Alimentary canal: No free fluid. The whole of the visceral and peritoneal surface was covered with small gelatinous grey nodules $\frac{1}{4}$ to $\frac{1}{2}$ in. in diameter, coils of small intestine being lightly adherent to each other, and in one or two places to the parietal peritoneum of the anterior abdominal wall.

Liver: Slightly enlarged, containing secondary carcinomatous deposits.

Spleen: Deposits on surface.

Right kidney: Slightly enlarged. Cut surface showed small ragged growth near upper pole. Pyelitis present.

Left kidney was represented by a large greyish mass 7 in. × 3 in., which was found on section to consist of growth, necrotic in places and completely replacing renal substance. In the centre of this mass, representing what had been pelvis and calyces, was an irregular cavity with ragged walls, which had contained the calculus removed at operation. The whole mass was densely adherent to the surrounding structures—vertebral column, muscles of posterior abdominal wall and peritoneum, all of which were extensively infiltrated.

Left ovary (removed at operation).

Right ovary atrophic.

FIG. 1.—A SECTION THROUGH THE LEFT KIDNEY SHOWING THE EXCEPTIONAL FORMATION OF CELL-NESTS AND KERATINIZATION. × 180.

Histological Report.

Left kidney.—Kidney substance almost entirely replaced by squamous-cell carcinoma, which shows an exceptional amount of cell-nest formation and keratinization (Fig. 1).

Right kidney.—Pyelitis present.

Peritoneum.—Secondary deposits with cell-nest formation and keratinization (Fig. 2).

Liver.—Similar secondary deposits.

The histological evidence in this case leaves no doubt that this is a case of squamous-cell carcinoma of the renal pelvis. The formation of the distant metastases with similar structure proves that it was a malignant change, and incidentally is in keeping with Schmorl's evidence.

In this case the three ætiological factors cited in the literature were all present. The size, weight, and striking lamination of the calculus removed at operation seems to show that the latter had been present for a considerable number of years. It would be interesting to know whether it was present in 1902 (the time of her previous operation), but since X-rays were hardly known at that time, no photograph was taken.

The hydronephrosis, on the other hand, as can be seen from the clinical history, was present in 1902, but reduced. Whether this condition returned is impossible to say, but it has been known to occur.

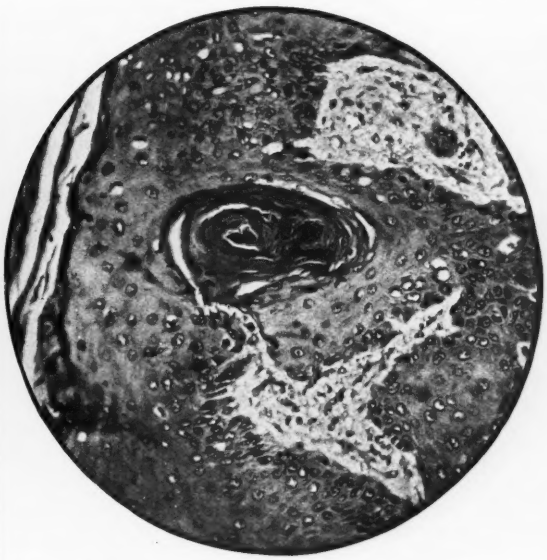

FIG. 2.—A SECTION THROUGH A PERITONEAL METASTASIS SHOWING SIMILAR ATYPICAL GROWTHS. × 180.

Whether the carcinoma was present in 1920 is a matter of conjecture. The literature states that these carcinomata are rarely slow growing; more probably the swelling in the groin was of another nature, *i. e.* pyonephrosis, stone or hydronephrosis.

However, the state of the urine in 1925 leaves no doubt that the pyonephrosis was then in existence and had continued to be present.

It is interesting to note also that pyelitis was present in the right kidney. If the histological report had stated leukoplakia was present, there might have been some justification in saying that a malignant change was taking place as outlined by Cumming. Bilateral carcinoma of the kidney have been recorded. Pyelitis, however, is not a sufficient proof.

In conclusion, I should like to thank Mr. Geoffrey Keynes for his kindness in allowing me to publish these notes, and Dr. Cullinan for obtaining the accompanying photographs and histological report.

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E. M. DARMADY.

SIR D'ARCY POWER'S SELECTED WRITINGS.*

SIR D'Arcy Power is an unassuming man, and probably it had never occurred to him that it might be worth while to collect and reprint some of his very numerous and scattered writings. The Bart.'s Nucleus of The Osler Club of London may therefore congratulate itself on its cleverness in seeing that Sir D'Arcy's seventy-fifth birthday might be most happily celebrated by presenting him with a volume of his own writings rather than with a *Festschrift* of the superfluous German type. The affection and respect of the donors is perfectly expressed in the volume before us, and the world is enriched by a collection of medical historical writings which perfectly reflects the author's character and interests. Sir D'Arcy Power's learning and wide reading sit upon him with the lightness of a feather, and who would have guessed the fact, revealed to us by the industrious compilers of the short-title Bibliography printed at the end of the book, that he has been guilty of at least 609 contributions to literature (and is probably still adding to his guilt)? With such a wealth of materials the Selection Committee, composed of the Bart.'s Nucleus, overlaid with a bevy of their elders gathered from various sources, can have had no easy task. Their duty was to cream the milk, but the cream could not be made into butter, and much of it must have been rejected for lack of space. The result is a richly filled volume which will commend itself to almost any palate. As might be anticipated, Surgery, Harvey, and St. Bartholomew's Hospital are well represented, but many other interests find a place.

John Hunter, the subject of the first paper, though a surgeon, was primarily a scientist, an honest scientist, moreover, who was notoriously abused, and fell a victim to his habit of experimenting on himself. Although the book is a compilation from scattered sources it preserves a certain continuity of subject and the general history of surgery is surveyed from several different angles in the next four papers, on fourteenth century practice, episodes in the history of Bart.'s, surgical education under Vicary, and the fees of our ancestors. Sir D'Arcy Power has varied his achievements by being President of the Bibliographical Society, and this side is represented by the sixth paper on three sixteenth-century books connected with London Hospitals. The interest of the books, however, is far from being merely bibliographical. The seventeenth century is given a good run in the persons of William Harvey, John Ward and Samuel Pepys. The two papers on Harvey give the results of much original research and are of the first importance. John Ward was the author of a voluminous diary, recently sold by the Medical Society of London to an American dealer for a very large sum. It contained some references to Shakespeare, which perhaps accounted for much of its monetary value, but it also had many things of medical interest, and Sir D'Arcy was the first to make a really detailed examination of the manuscript, some of the results being given in his address reprinted here. As for poor Mr. Pepys, Sir D'Arcy has diagnosed what was wrong with his eyes and has prescribed the correct glasses, but unfortunately more than 230 years too late to enable him to continue his *Diary*. The history of The Royal College of Surgeons, of which Sir D'Arcy has so long been an active servant, is surveyed in the eleventh paper, and the remainder of the book is given up to more strictly surgical subjects. Sir D'Arcy's numerous articles on eponyms contributed to the *British Journal of Surgery* are represented by one on Spencer Wells' forceps. Surgical history is further developed in an account of the relation of surgery to comparative medicine, and of how the British tradition came to America. Sir D'Arcy's more technical contributions on surgery are limited to the last two papers on the wiring of aneurysms and on cancer of the tongue. It may be true, as Lord Moynihan hinted in his remarks when making the presentation, that Sir D'Arcy is represented by this book chiefly as a truant from the

* *Sir D'Arcy Power Selected Writings*, 1877–1930. (Oxford: The Clarendon Press, 1931.) Pp. x + 368. Illustrated. 25*s*. net.

strict path of surgical practice, but had he not been truant he would not have been the beloved figure that we see looking at us from the frontispiece and passing gaily through the pages of this book. His contribution to pure surgery might have been greater, but to the humanities he would not have added so much, and it is as the humanistic historian that he will be remembered. There can be no doubt that this book will keep his memory green for many years to come. It is excellently printed, bound and illustrated, and is so attractive in every way that it may be doubted whether the 253 subscribers have left enough copies over to satisfy the demand among those who were unwise enough not to join their ranks. ST. D.

INDEED THE IDOLS.

"Depart from the highway and transplant thyself in some enclosed ground, for it is hard for a tree which stands by the wayside to keep her fruit till it be ripe."

WHEN day by day enthusiastic men and women are adding, sometimes with plodding precision, sometimes with dramatic suddenness, to the sum total of medical wisdom, it is not surprising if day by day new specialties spring fully armed out of Apollo's forehead. Each has its own department in hospital and consulting practice, and ever attracts fresh and eager minds to its loyal service. But what Daniel will arise to interpret the mystic writing on the wall of one of our youngest specialties, that of medical librarianship? Cruelly neglected by student, practitioner and consultant alike, to each and all it offers so much and it means so little. How rarely are we privileged successfully to put our difficulties, great and small, real and imagined, before our colleagues, teachers, and "betters," whose sympathy may be endless, but whose time, patience and mental resources are after all strictly limited! In the ideal republic of medicine the librarian would play a truly indispensable *rôle*. Exoriare aliquis nostris ex ossibus . . . Time is in travail. Who can predict what rare fruit it may in the end produce? This country is the noble guardian of some of the finest medical libraries in the world, which strangely lack high priests who by the earnestness of their devotion and by the warmth of their sympathy attract the congregation. Seekers after the Hidden Wisdom are ever received most courteously and indeed like honoured guests, but how often do they not depart empty-handed from these mausoleums of dead ideas!

Visitors to the Library of the Royal College of Surgeons of England saw little of their distinguished late librarian. Though he did not altogether shun visitors, the mantle of reserve, idiosyncrasy and mental inertia weighed heavily on his bent shoulders, and the depth of his feeling and the fineness of his intellect too often lay hidden behind the mask of cynical aloofness. And yet his cynicism was rarely destructive, but usually of a purely intellectual kind. Indeed there were occasions when he grew almost expansive and his conversation became a rare delight.

Victor Gustave Plarr, born in Alsace under the French flag, came to England at the age of seven. The hand of heredity and the magic touch of Oxford led him into the pleasant fields of literature, which he adopted as a profession. He made a scanty living by writing verse, contributing articles to the Press, and translating from the Greek and French. As a journalist he never became successful, for his wares were not such as were prized in the market-place As a poet he failed to impress his generation, and to-day takes his place with the minor poets. In 1890, King's College, London, offered Plarr his first post, the shelter of its Library, and, seven years later, he became Librarian of the Royal College of Surgeons. As Librarian he failed to attain that height of greatness and efficiency which his opportunities so richly promised, though he rendered valuable service to the College and to the profession at large by bringing the Library Catalogue up-to-date, and by compiling a hand-list of the manuscripts in its possession. His artistic and uncertain temperament constantly led him into bypaths, and prevented him from concentrating on the work that is nearest. He lacked that scientific accuracy and concentration which Osler calls the ballast of the boat. The strength and the weakness of his character he displayed to the full in the biographical dictionary of the Fellows of the Royal College of Surgeons, which he was asked to prepare in 1912. Face to face with this encyclopædic undertaking—the most ambitious and momentous in his life—he found himself in the glorious company of wise professional leaders who had ever fostered the growth of their craft, and of silent workers of the ranks who little expected that the curiosity of future ages should comment upon their ashes. To him the lives of both were a moving tale of dreams and aspirations, of disappointment and failure—a tale which for him held a deeper interest than the faithful record of their achievements. Tenderly sensitive to the lights and shades of life's landscape, he was, as Sir Arthur Keith has said of him, "a spectator who sank himself in his surroundings and watched life go by—sometimes with a wry smile." He loved to depart from the high road, to linger by the still waters, and to explore the kindly spots of hill and vale. As he wandered with Epicurus on his right and with Epictetus on his left,

illness overtook him, and, his work unfinished, he disappeared into the night. Though ever beyond the distant hills his eyes had feasted on the vista of the promised land, his was the tragic fate of Moses of old. Future historians will say of him that the Delectable Mountains of artistic perfection he was not destined to scale. His biographical sketches were curiously imperfect documents, pickled in irony, sweetened with regret. Here and there the briefest of entries—mere records of birth and death. Here and there pious obituary notices of men upon whose tombs the echo of eulogy had scarcely died away. Here and there arrestingly fine pen-pictures of a man with his thoughts and dreams, painted with reverence and delicate charm. It was left to the scholarly care of Sir D'Arcy Power, Mr. W. G. Spencer and Prof. G. E. Gask to verify Plarr's references, to rectify his mistakes, to show impatience where his caprice had been too leisurely, and to be eloquent where he had been but careless in his brevity. Thus *Plarr's Lives* have been produced—a work which students of medical history appreciate as a never-failing source of much varied and interesting information, and students of human nature as a worthy monument to one who has set a new fashion in medical biography.

W. R. B.

THE DISILLUSIONED DOCTOR.

SICK of drugs and sick of diet
How to keep my patients quiet!
Serums, vaccines and syringes
Cease to ease their pangs and twinges.
Colloid states of precious metals
Now replace old roots and petals.
Macerations of the tissues
Check the flow of bloody issues,
Thin the fat, make old men younger,
Stay the diabetic's hunger.
Little children when they pray,
Praise the ultra-violet ray,
Yet the world goes round and round,
Worms still fatten in the ground.

H. MUIR EVANS.

DIABOLISMUS.

THE collection of antique spoons, the study of medicine, the flying of kites are hobbies usually harmless, sometimes even beneficial; but, given what we may term the Diabolic diathesis acting in a suitable environment, the collector turns his attention to modern spoons and ceases to be a welcome week-end guest, the doctor begins to write weekly articles on the treatment of varicose veins, and the kite-flier is found brooding over rockets and the nearer planets. Such syndromes as these are termed collectively *Diabolismus*, or Toxic Hobby.

A few of the commoner forms of this disease must be called to mind before we embark on a rather more detailed study of one of the less known but more interesting.

Diabolismus regalis antiquus needs no description, for who does not know the Golf Fiend? For him, as for most of these cases, there is little treatment. One must guard, if possible, against any rapid reduction of his handicap, for this is apt to produce a severe exacerbation of his symptoms. Tremor of the hands and a trace of foot-drop at the end of a long spell of wet weather should be disregarded.

Diabolismus pontis, a condition most commonly found in elderly women, is interesting for the curious contrast it presents to general paralysis of the insane. The crisp speech, the immobile lips, the "austere regard of control," the mental acuteness *increasing pari passu* with moral deterioration, and, above all, the delusions of penury make the Bridge Fiend a very exact antithesis of the expansive male who is the type of general paralysis.

Diabolismus venatorius is a distressing familial form, endemic in Leicestershire, and quite uncommon in the out-patient department of the greater hospitals. This form, too, leaves its mark upon the character. As in acute alcoholism, the patient regards all who are not similarly afflicted as abnormal, the objects of profound distrust: but the advent of a fellow-sufferer or of a horse may elicit a shrill cry of "Yoi-oicks!" or worse, a story of a thirteen-mile run without a check. An almost constant accompaniment is a partial colour-blindness for scarlet, which the patient persists in regarding as pink.

The *Diabolus philatelicus*, or Stamp Fiend, is a more pleasant subject for contemplation. The syndrome commonly shows itself first in middle childhood, and in about 80% of cases leads to a spontaneous cure at the age of 12 to 14. In children it may give rise to attacks of stamp-mount dyspepsia—a rare complication unknown in the adult, who has a high tolerance for gum

taken by mouth. If the symptoms persist beyond the age of thirty they may be regarded as incurable. Yet they have little effect on the general health, and the sufferer may remain a happy and useful member of society. One case, indeed, which has been under my care for some years, is that of a churchwarden.

Only two cases have so far been recorded of the *Diabolismus of Rabelais*, of which the only symptom is a tendency to collect and mount in cases handles labelled PULL. The syndrome appears to be confined to adolescence: it runs a benign course and is self-limiting in one or two years.

Slightly less rare, and perhaps the most interesting of all forms of this disease, is *Diabolismus locomotivus* ("d. chemin de fer"). The Train Fiend (or *Schnellzug diabolus*) is invariably a male. At the age of about three he frequently exhibits a significant prodromal symptom—a desire to become an engine-driver. More often than not this will pass off and the disease appear arrested. Three or four years later, however, it may be noticed that the railway-lines commonly found in a corner of the child's nursery are spreading, first over the whole floor-surface of the nursery, then gradually further out onto the landing. If they can be checked here, there is every hope of the patient's recovery in a year or two, but if he is allowed to invade a second or third room with his rail-system or—a still more ominous sign—if he is found nailing his rails to the floor-boards, there is a grave danger that the disease-process may run on into adult life. What has been in childhood a turbulent but narrow stream of consciousness, fed only by the images of a few models, becomes suddenly a broad river swollen by an ever-widening conception of the vast railway-systems of the world.

From now on the mature Train Fiend will exhibit a number of curious symptoms, of which (to adapt the great lines of Lewis Carroll)—

> "The first is his fondness for railway-trains,
> Which he frequently follows about;
> He believes that they add to the beauty of scenes—
> A sentiment open to doubt."

He may enter a train, for instance, at Paddington, travel rapidly to Birmingham, and there cross to the "down" platform just in time to catch a return train to London: all this to see a particular train pass through the junction or to catch a glimpse of a new type of engine which he has traced to its home shed. Sometimes he may be found in a corner seat on the Flying Scotsman or the Cornish Riviera; here he sits, stop-watch in hand, peering at the edge of the permanent way, where, every fifteen seconds or so, the white quarter-mile posts flash by. (It is to be noted that he spurns the information which the accommodating Mr. Carter has coupled with his glad news of Little Liver Pills. "Not very accurate" is his usual comment.)

Thus, or from genial drivers in the more penetrable engine-sheds, he gathers his facts. With these at his finger-tips he seeks the company of his fellow-fiends, and it is when two or three are gathered together that this Diabolismus takes on its most dramatic form. An outbreak may occur at any social gathering, be it at a private view or on a raft in mid-Atlantic. A few quiet words are exchanged, and suddenly the air is clangorous with technicalities, as the victims stand and cast superheaters and Westinghouse brakes, King Arthurs and Pacifics, C-class tanks and 4—6—2's in one another's teeth. Death has not been known to occur during these acute attacks, although cerebral hæmorrhage sometimes appears imminent in plethoric types of Train Fiend. At the end of one such flare-up of symptoms which I was privileged to witness, two of these men remembered for the first time that they had seen each other for some years at the same public school, simply because they both claimed to have been "brought up" on the same stretch of railway-line. The school, it seems, had fed and lodged them, while the Great Western Railway, all unconscious, provided their education.

Some clinicians have classed the *Bradshaw* Fiend with the Train Fiend. This is an error, for the two types, although closely related, are distinct. The Train Fiend is no mere statistician; to him the *Railway Magazine* is the true Bible, and *Bradshaw* a mere Book of Hours. Motor omnibuses and the Air Mails are minor objects of worship—(perhaps because they resemble trains in their grouping into "routes" and their attempt to adhere to a schedule. Uncertainty provides constant stimuli). Private motor cars he regards with interest, but not with reverence; his own is but the means to hasten to his platform and engine-shed devotions. A typical case was that of a young Scotsman who drove forty miles in a borrowed car to spend a long afternoon on Reading station. When he returned, his only words were: "Think, man, two Pacifics in one afternoon!"

There is no treatment. A series of long sea-voyages may be advised, but seldom prevents the return of either symptoms or patient. W.

ACKNOWLEDGMENTS.

The British Journal of Nursing—The British Journal of Venereal Diseases—Bulletins et Mémoires de la Société de Médecine de Paris—Charing Cross Hospital Gazette—The Clinical Journal—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital—The Kenya and East African Medical Journal—King's College Hospital Gazette—The Leech—Medical Times and Long Island Medical Journal—The Nursing Times—St. Mary's Hospital Gazette—St. Thomas's Hospital Gazette—The Student—Upsala Läkareforenings Förhandlingar.

ABERNETHIAN SOCIETY.

A Clinical Evening was held in the Abernethian Room on Thursday, January 15th, at 5.30 p.m., the Vice-President, Mr. J. S. MacVine, being in the chair.

The minutes of the previous meeting were read and confirmed and the following cases were then shown:

Mr. Westwood: A case of pyopneumothorax.

Mr. Hayward: A case of actinomycosis of the lungs.

Mr. Cusack: A case of polycythæmia and the result of treatment with phenyl hydrazine.

Mr. Kersley: A case of diverticulum of the small intestine.

Discussion followed each case, in which Messrs. Prowse, Oakley, Beard, Ishmael, Keele and Fawcett took part.

A vote of thanks to those members who had shown cases was proposed by the Chairman and carried unanimously.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

Hospitals' Cup.

ST. BARTHOLOMEW'S HOSPITAL *v.* GUY'S HOSPITAL.

Result: Won 8—0.

February 17th, at Richmond.

On club form and the opinion of most followers of the game Guy's were almost certain to win, but, as is usual in cup-ties, the brilliance of individuals, especially behind the scrum, can be discounted by determined tackling.

At first the quickness of the Guy's backs repeatedly started dangerous-looking movements, until it was to be noticed that they were only on the rarest occasions able to shake free the swarms of spoilers who fastened on every passing movement. Johnson, on the left wing, one of the Guy's stars, was quite unable to slip D. M. Thomas, who brought him to earth with amazing vigour and ruled him out as far as try-scoring was concerned. There was no score in the first half, partly owing to the fact that both forwards and backs were too busy discouraging Guy's to risk any opening-up of the game; it became, indeed, what the historians would call a soldiers' battle with very heavy casualties.

In the second half, however, things brightened up, and Taylor tried his famous steal-away, kicked past the full back and would have scored but for an illegal tackle by the full back. Unfortunately the penalty kick failed. Then Nunn, in the middle of another attacking movement, punted ahead, and Prowse, following up, took the ball well and, with a good pass, sent Thomas down the right wing. At just the right moment Thomas gave Nunn an inside pass and he raced over to score a try, which crushed the Guy's supporters and elated those of Bart.'s to a state of frenzy. Ryan converted with a good kick. Windsor Lewis now tried to set up an attack, following a penalty, by a touch into his own hands and a quick pass out to his centres. The Bart.'s backs were on the alert, however, and an interception by Petty sent them in full cry to the Guy's line. Petty was tackled before reaching it but the ball went loose, and Thomas, with commendable presence of mind, did not attempt to pick up, but dribbled over and touched down.

Among the forwards R. N. Williams was perhaps the best of a most lively and determined pack, all of whom worked like heroes.

Bart.'s thus finished the winners by 8—0 and qualified for the semi-final on March 3rd.

Team: T. J. Ryan (*back*); D. M. Thomas, G. F. Petty, C. B. Prowse, J. D. Powell (*three-quarters*); J. A. Nunn, J. T. C. Taylor (capt.) (*halves*); R. N. Williams, V. C. Thompson, H. D. Robertson, B. S. Lewis, J. R. R. Jenkins, E. M. Darmady, R. Mundy, G. D. S. Briggs (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* BRIDGWATER ALBION.

Result: Won, 6—0.

January 31st, at Bridgwater.

This was a new fixture, and turned out to be a very enjoyable one in spite of deplorable weather conditions. Bart.'s were the superior side from the start, and after ten minutes Pirie ran over from a good passing movement to score far out. The kick was a very difficult one and Ryan failed.

Towards the end of the first half Taylor exploited his steal-away and scored a good try. Ryan could not convert.

The second half resolved into a desperate struggle by the home team to score with the help of wind, hill and rain, and a dour defence, with occasional attacks by Bart.'s.

The game, however, ended without further score, leaving Bart.'s the winners by 6 points to *nil*.

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD PAULINES.

Result: Won, 16—6.

January 24th, at Winchmore Hill.

This was a rather scrappy game, owing to the slippery ball and freezing wind, but under the circumstances the Bart.'s handling was quite creditable. Thomas and Powell scored tries for Bart.'s in the first half, the former after a strong run, and Ryan converted.

The Old Boys kicked a penalty goal, after three or four attempts, each nearer the Bart.'s goal.

In the second half Powell and Prowse scored for Bart.'s and Ryan converted the latter. The try by Powell was the result of a good movement between Prowse and Powell, the ball changing hands several times. Bart.'s thus finished the winners of a rather unenjoyable game, packed with penalties on both sides.

ASSOCIATION FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. JOHN'S COLLEGE.

January 24th, at Cambridge.

This match resulted in a win for St. John's by 4 goals to 1. The score rather flattered the winners, as the play was very evenly divided. Bart.'s scored first through Dransfield, and at half-time the score was 2—1 in St. John's favour. Bart.'s made many attacks on the John's goal in the second half, but weak shooting was the cause of our failure to score.

ST. BARTHOLOMEW'S HOSPITAL *v.* EMMANUEL COLLEGE.

January 31st, at Winchmore Hill.

In this game, played on muddy ground, the Emmanuel forwards were too fast for the Hospital defence, and at half-time the visitors were winning 2—0. In the second half the Bart.'s forwards failed to combine and could not get away. Emmanuel scored two more goals and kept the Hospital on the defence for the greater part of the game.

First Round Inter-Hospitals Cup.

ST. BARTHOLOMEW'S HOSPITAL *v.* KING'S COLLEGE HOSPITAL.

February 3rd, at Winchmore Hill.

This match resulted in a rather easy win for Bart.'s by 8 goals to 2. Bart.'s scored first, then King's drew level, and for a time play was very even. Then Bart.'s forwards combined very well and the score at half-time was 3—1 in our favour. In the second half Bart.'s were definitely superior and kept King's on the defensive all the time. Five more goals were scored for Bart.'s

Scorers: Dransfield 4, Wheeler 1, Hughes 1, Shackman 2.

Team: E. E. Brown (*goal*); D. R. S. Howell, H. J. Roache (*backs*); J. Crumbie, C. A. Keane (capt.), G. H. Brookman (*halves*); R. G. Gilbert, R. Shackman, C. M. Dransfield, F. E. Wheeler, J. Hughes (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* DOWNING COLLEGE, CAMBRIDGE.

At Winchmore Hill on February 7th.

This match resulted in a draw, 3—3. The play was very fast and even for the whole of the game; half-time the score was 1—1. In the second half Bart.'s did most of the attacking and were unlucky

in not scoring more. Goals were scored by C. M. Dransfield (2) and H. J. Roache (1).

Team: R. A. Wenger (*goal*); J. Crumbie, D. R. S. Howell (*backs*); A. Hollinrake, C. A. Keane (capt.), G. H. Brookman (*halves*); R. G. Gilbert, R. Shackman, C. M. Dransfield, F. E. Wheeler, H. J. Roache (*forwards*).

First Round Junior Inter-Hospitals' Cup.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. THOMAS'S HOSPITAL.

February 12th, at Chiswick.

Bart.'s won the toss and, kicking with the wind, attacked vigorously for the first 10 minutes, but without result. Mid-field play followed, but after about 20 minutes' play Jackson cleverly intercepted a backward pass by one of Thomas's backs, and scored a good goal. Bart.'s attacked for most of the first half, but failed to press home their advantage, half-time being reached with the score 1—0 in our favour.

Thomas's, with the wind in their favour, attacked hard for the first 15 minutes of the second half, but our defence played superbly, particularly the half-backs. After about 20 minutes McAskie, who played in his best form throughout, scored a very good goal from a pass from McKenzie. This goal proved the turning-point in the game, Bart.'s attacking consistently during the remainder: further good goals were obtained by McAskie and Jackson. Result: Bart.'s 4, St. Thomas's 0. This was a very good performance of our 2nd XI, every man playing in irresistible fashion.

Team: D. J. Johnson (*goal*); G. A. Mendow, R. McGladdery (*backs*); L. A. Hiscock, A. E. Owlett, A. Hollinrake (*halves*); J. K. McKenzie, W. A. Owen, B. F. Jackson, L. McAskie, S. Barrigrasser (*forwards*).

HOCKEY CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. ALBANS.

Result: Drawn, 2—2.

January 24th, at St. Albans.

This very close game quite properly ended in a draw. We were fortunate in having Roles to take Jameson Evans's place at inside right. Doing most of the attacking at first, we had two goals to our credit through Heasman and Owston before our opponents had scored. Later, after making some changes in their forward line St. Albans became dangerous, and by ten minutes before time they had managed to draw level. These last ten minutes were exciting; more than once they would have scored again had not Gale and Henton-White, our backs, and Smallhorn, who was taking Hodgkinson's place in goal, put up a stout defence. The two outsides, Symonds and Davidson, played excellently, centres from them being responsible for each of our two goals.

Team: T. Smallhorn (*goal*); F. C. Henton-White, D. Gale (*backs*); V. C. Snell, A. D. Iliff, J. H. Hunt (*halves*); R. T. Davidson, F. C. Roles, A. J. Owston, L. Heasman, J. Symonds (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* R.N. and R.M., CHATHAM.

Result: Won, 7—2.

January 31st, at Chatham.

With a full team out for the first time since Christmas it was encouraging to win this match by so large a margin. Our game seemed to be greatly improved, the ball was swinging about from wing to wing in a way we like to see, and the forwards, passing through the opposing backs, gave themselves plenty of chances, most of which they took. Owston scored three of our goals, being unfortunate to miss another, a fine shot, which passed just over the cross-bar, over a fence and out of the ground; Heasman scored twice, and Davidson and Symonds one goal each.

Team: H. L. Hodgkinson (*goal*); F. C. Henton-White, P. M. Wright (*backs*); V. C. Snell, A. D. Iliff, J. H. Hunt (*halves*); R. T. Davidson, L. P. Jameson Evans, A. J. Owston, L. Heasman, J. Symonds (*forwards*).

FIRST ROUND INTER-HOSPITAL CUP.

ST. BARTHOLOMEW'S HOSPITAL *v.* CHARING CROSS AND ROYAL DENTAL HOSPITALS.

Result: Won, 4—1.

February 4th, at Winchmore Hill.

The first ten minutes of this game gave us many anxious moments, as we were slow in getting together and their forwards several times looked like scoring. But soon we made up for the bad start, our forwards playing excellently, giving each other long through passes and following them up well.

Owston scored our first two goals. Soon after this our opponents scored, after a run down the wing by their right outside, a misunderstanding amongst our defence leaving two men unmarked. Our backs were hard pressed for the next few minutes, being nearly beaten once again, Hodgkinson just saving a shot from in front of goal by turning it round the post with his knee. This was fortunate for us; if they had drawn level at this point the result might well have been very different.

Our third goal came from Hay-Shunker, and just before half-time a fourth from Jameson Evans, a good oblique shot from the right wing.

The second half of the game proved disappointing and somewhat scrappy; although we were playing downhill, and attacking nearly all the time, the soft ground being cut up made the game difficult for our forwards, and we did not score again.

Wright and Henton-White at back, Iliff at centre half, and Owston at centre-forward, were all playing well.

Team: H. L. Hodgkinson (*goal*); F. C. Henton-White, P. M. Wright (*backs*); V. C. Snell, A. D. Iliff, J. H. Hunt (*halves*); L. P. Jameson Evans, C. L. Hay-Shunker, A. J. Owston, L. Heasman, J. Symonds (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* R.M.C., SANDHURST.

Result: Drawn, 3—3.

February 7th, at Sandhurst.

On a fine day, on an excellent ground, this proved to be one of our best games this season. We were fortunate in having J. A. Nunn in Davidson's place, and Gale, by chance at Sandhurst that afternoon, played instead of Owston, who had missed his train. From the bully-off we nearly scored, a fine run down the field by Nunn ending in a shot which the goal-keeper stopped above his head. In spite of several more rushes by our forwards, the R.M.C. were the first to score. The game was fast and the play even, but just before half-time Jameson-Evans made us level.

Early in the second half Jameson Evans scored once more, but they again drew level. After a long run down the wing, ten minutes before time, Symonds sent across the goal-mouth a high pass, from which Nunn scored, having jumped to stop the ball with his hand above his head. We were unable to keep the lead, even at this point in the game, as they yet again drew level just before the end. Smallhorn in goal saved some hard shots, and Gale, in an unusual place, at outside right, had several good runs down the wing.

Team: T. Smallhorn (*goal*); F. C. Henton-White, P. M. Wright (*backs*); V. C. Snell, A. D. Iliff, J. W. Hunt (*halves*); D. Gale, L. P. Jameson Evans, J. A. Nunn, L. Heasman, J. Symonds (*forwards*).

UNITED HOSPITALS HARE AND HOUNDS.

UNITED HOSPITALS HARE AND HOUNDS *v.* ORION H.

Held over the Hospitals' course at Richmond, on Wednesday, January 28th.

The course was in good condition, and the weathered favoured fast times. The Orion turned out a small, though strong team, while the Hospitals were without several of their best men. At the start Ries and Elgie (O.H.) took the lead, with Strong (U.H.) hanging on. The first 3 miles were run at an extraordinarily fast pace. About here Elgie began to tire and had soon dropped back, while Ries began to draw away from Strong. For the next 2 miles there was little change, but then Ross, the Orion 10-mile champion, made one of his fine efforts, and passing Strong, set out after Ries, who by now had a 50 yards' lead. Ries, however, continued to run very strongly, and covered the 6-mile course in the record time of

35 min. 15 sec., Ross being 150 yards behind and Strong another 70 yards further back. Elgie (O.H.) was fourth, while Sandiford, who was just recovering from the effects of "District," ran in with Lee for fifth place.

Result: Orion H. (1, 2, 4, 7, 8), 22 pts.; U.H.H.H. (3, 5, 6, 10, 12), 36 pts.

UNITED HOSPITALS HARE AND HOUNDS *v.* BLACKHEATH H.

Held over the Hospitals' 6-mile course at Richmond on February 11th.

The afternoon was one of the worst of the season. There was a high wind and rain, and the course was in a relatively water-logged condition. With a slow start Smith and Newson (Blackheath), with Strong and Sandiford (U.H.), took the lead, with the rest of the field following close behind. At about 2 miles Newson dropped back and Smith took the lead. Sandiford and Strong, however, took up the challenge with such effect that Smith was forced to drop back. From 4 miles onwards the two Hospitals men ran together unchallenged and eventually won in the good time of 36 min. 16 sec., Smith running in third, about 100 yards behind. It had been hoped to establish a new course record, which is now held by a visitor, but the weather must be blamed for the failure. G. Dally (U.H.) ran a splendid race, and by coming in sixth helped to secure a victory for the Hospitals in a match which would otherwise have resulted in a draw.

Result: U.H.H.H. (1, 2, 6, 8), 17 pts.; Blackheath H. (3, 4, 5, 7), 19 pts.

CORRESPONDENCE.

ST. BARTHOLOMEW'S SIXTY-THREE YEARS AGO.

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—In the October, 1930, number you had reminiscences of fifty-seven years ago, and you mention in your Editorial the Introductory Address in 1867, when the Treasurer was so badly treated.

It was my first year at Bart.'s and I was present on that occasion. Besides the pea-shooter, any amount of nuts were thrown on to his bald pate, he was jeered at, and there was an awful row. Having just joined I knew nothing about his unpopularity and didn't join in the throwing. What surprised me was that he sat quietly in his seat and never even turned his head. How differently Tom Smith, who gave the address in 1868, would have behaved! He would have jumped up like a shot and have slanged anyone who dared make a row or throw anything; and if Savory had been making the address he would simply have got up, turned round and sneered, and there would have been dead silence.

In my first year the Fenians blew up part of the wall of Clerkenwell Prison and part of some houses on the other side of the street, and the injured were brought to Bart.'s.

A friend, a fellow student, and I were in the out-patient room when they were brought in and helped with the dressings, and when we had finished we went to see the scene of the explosion. We couldn't get anywhere near. Thousands of people had assembled. I said "Come along," and went to the nearest "Bobby," as we then termed a policeman, and told him that we had just attended to the injured and wished to tell Sir Richard Mayne, then Chief of Police, about them if he was there. He said, "Yes, he is right in front," and took us there after a good deal of pushing. I told Sir Richard about the number and nature of some of the injuries, and then we had a good look round. Besides the Prison wall the whole of the front walls of many houses were blown away, and the fireplaces, bedsteads and other furniture exposed. They were workmen's cottages, very thin walls.

I am afraid I have trespassed too much already on your space, but if you would care to have more reminiscences I could relate all about the last hanging in public of the man who caused the above, which we saw, and also reminiscences of the great surgeons and physicians of those days, for, besides out-patient work, I dressed for Savory and clerked for three physicians.

G. T. LANGRIDGE,
Lt.-Col. R.A.M.C. (ret.).

February, 1931.

"PAGET'S 'QUIET NECROSIS.'"

To the Editor, 'St. Bartholomew's Hospital Journal.'

DEAR SIR,—

"And she named the child I-chabod, saying, 'The glory is departed from Israel.'"

We cannot all be historians. The shrill voice of priority ever leads the frail among us astray, and their historical voyages end in the tragedy of shipwreck. As long as there are men to practise the art of medicine, so long will they speak with the tongue of piety and reverence of those who, to their own undying glory, have erected noble monuments in many a clinical entity which has become the common property of science. Like myself and many others, my friend J. M. Jackson has had his historical temper aroused by that strange challenge in the new edition of *Bowlby and Andrewes*, which boldly associates the term "quiet necrosis" with Morrant Baker's name. When men are sufficiently provoked, they produce good work. But when I read the innocent statement, "It remained for Sir James Paget to apply the name of 'quiet necrosis,'" my pride as a Bart.'s man is grievously wounded. If no single discovery is ever due to one individual worker, may I protest that the credit should go to the man who, believing in its importance, succeeds in converting the world to his creed? Paget's name is inseparably linked with "quiet necrosis," not because he was the first to baptize or even to describe it, but because, even though unable to explain its nature, he was always anxious to impress upon the profession to bear its possibility in mind in any obscure bony swelling.

I am, Sir,
Yours faithfully,
W. R. BETT.

SHADWELL, E.;
February 1st, 1931.

REVIEWS.

AN INTRODUCTION TO MEDICAL HISTORY AND CASE-TAKING. By GEOFFREY BOURNE, M.D., F.R.C.P. (Edinburgh: E. & S. Livingstone, 1931.) Pp. xii + 195. Price 6*s*.

The size of this book is no indication of its value, for it is small enough not to frighten the laziest student and yet large enough to carry much clinical wisdom. It is intended as a first guide in the approach to the patient, and is not meant to replace books of reference to clinical methods. It is broadly conceived and attractively written. We liked particularly the well-balanced chapter on the necessity for making a diagnosis and how to set about it. The specimen case, showing the procedure for formulating a diagnosis, is most helpful. There are one or two minor points which we would like to add, *e.g.* cyanosis without dyspnœa may occur from a pulmonary cause, as in emphysema (p. 106). But, considering the book as a whole, we are of the opinion that any medical student will be the better for having studied it. In the preface, we should like to add, is a practical tribute to the teaching of Dr. J. H. Drysdale, to whom the book is inscribed.

SENSATION AND THE SENSORY PATHWAY. By JOHN S. B. STOPFORD, M.D., F.R.S. (London: Longmans Green & Co., 1930.) Illustrated. Pp. xii + 148. Price 7*s*. 6*d*.

To clinicians sensation is a physiological function perplexing to understand and difficult to estimate. They therefore welcome any clear and concise account of the anatomical pathways associated with sensation and a lucid interpretation of the physiological considerations of such pathways. The author is to be congratulated on the merits of this work. Wisely the clinician's interest is early engaged by a discussion as to the sensory disturbances associated with regenerating nerves; he is then led on to an able treatise regarding the peripheral and central sensory pathways. Finally the author discusses the two systems in both cutaneous and deep sensibility and offers an explanation of the two-stage recovery met with following nerve suture. It is in the later chapters that controversial subjects are dealt with, and though all may not agree with the author's explanations, all must admit that he has offered a welcome and useful hypothesis. All interested in sensation, be it subjective or objective, are recommended to a study of this book.

TEXTBOOK FOR NURSES. By E. W. HEY GROVES, M.D., F.R.C.S., and the late J. M. FORTESCUE-BRICKDALE, M.D., M.R.C.P. Fourth edition. (Oxford Medical Publications, 1930.) Pp. xxx + 641, 229 illustrations. Price 20*s*.

This well-known text-book deals with anatomy, physiology, surgery and medicine in such detail as will enable the nurse to understand the principles underlying medical and surgical treatment. The book is sufficiently comprehensive to be used for reference and the General Nursing Council syllabus is adequately covered. Nursing technique is not included. The anatomical section is clear and concise, and is beautifully illustrated. The physiology part is accurate and up-to-date. The section dealing with medicine has been revised by Prof. J. A. Nixon, and includes much recent work, especially on specific infections. The subject of dietetics is perhaps rather inadequately dealt with; a clearer exposition of the principles of diet in alimentary, renal and metabolic diseases would be a great advantage. The chapter on war surgery has been omitted, and the contents of it have been distributed through the book. A few skiagrams of fractures and of various conditions of the alimentary canal would be an interesting and helpful addition.

The authors are to be congratulated upon the accuracy and simplicity of this book, and the publishers upon its attractive appearance and reasonable price.

SURGICAL EMERGENCIES IN PRACTICE. By W. H. C. ROMANIS, F.R.C.S., F.R.S.(Edin.), and P. H. MITCHINER, M.S., F.R.C S. (London: J. & A. Churchill, 1931.) Pp. viii + 608. 158 illustrations. Price 18*s*.

This book is designed for practitioners who have no time to wade through the paragraphs dealing with pathology and alternative methods of treatment in the larger text-books. Clinical features, differential diagnosis and the best line of treatment are dealt with more or less briefly. It is indicated where expert advice should be obtained. Technique of emergency operations is merely outlined. The chapters on fractures are extremely good, full details of treatment being given and many illustrations provided. The recent method of using local anæsthesia in reducing fractures deserves full description, since it is likely to be very useful to the country doctor. It is, however, only briefly alluded to by the authors. Antiquated splints have been omitted; it appears, indeed, that metal and wooden splints are almost confined to first-aid work; the technique of applying plaster splints is fully described. The authors insist on frequent skiagrams to ensure that the fragments are maintained in good position. A useful section deals with improvization of necessities for an abdominal operation.

Infections of the hand are fully dealt with, as their importance merits. A diagram of the surgical anatomy of the hand, showing the tissue spaces, tendon sheaths, vessels and nerves with the various incisions would be a useful addition.

The book is attractively got up, well illustrated and reasonably priced. It contains many of the features which have made the authors' *Principles and Practice of Surgery* so deservedly popular, but there is practically nothing in it which is not given in fuller detail in the larger work, and we consider that it is unlikely to replace it on the bookshelf of the practitioner, however pressed for time.

MINOR SURGERY AND BANDAGING By GWYNNE WILLIAMS, M.S., F.R.C.S. Twentieth edition. (London: J. & A. Churchill, 1930.) Pp. viii + 445. 262 illustrations. Price 10*s*. 6*d*.

That this little book has reached its twentieth edition is sufficient evidence of its usefulness. It has been brought up to date, and can be confidently recommended to the dresser as a most valuable investment, since it contains many details and helpful hints not found in the large text-books. The injection treatment of varicose veins is briefly described, and the chapters on fractures have been considerably extended and more fully illustrated. Not the least useful is the chapter on bandaging, which is by way of becoming a lost art.

HANDBOOK OF DISEASES OF INFANTS AND CHILDREN. By F. M. B. ALLEN, M.D., M.R.C.P. (London: Baillière, Tindall & Cox, 1930.) Pp. vii + 595. Price 15*s*.

The object of this volume, as stated by the author in the preface, is to present the subjects in a concise and complete form in order to be of service to medical students preparing for the final examinations, as well as to general practitioners who wish to acquaint themselves with modern views on the subject of diseases of children, and particularly the problem of infant feeding. In this aim he succeeds to a large extent, mainly as a result of copious quotations from the various standard authorities on diseases of children, but in the outcome the book has lost all trace of individuality, and has become to a large extent a compendium of the views of many pædiatricians, of greater or lesser reliability, on the various aspects of disease in childhood. It is difficult to discover, however, any advantage in this text-book as compared with the numerous other standard works on the subject, nor does it seem probable that it will replace them, either as a text-book for the use of the student or as a standard of reference for the general practitioner.

ANTE-NATAL CARE. By W. F. T. HAULTAIN, O.B.E., F.R.C.S. (Edin.), and E. CHALMERS FAHMY, F.R.C.S.(Edin.). Second edition. (Edinburgh: E. & S. Livingstone, 1931.) Pp. 127. Price 5*s*.

That this book has reached its second edition in so short a time is sufficient indication of its worth. This is the only book which deals exclusively with the all-important subject of ante-natal care. This subject has been attracting an increasing amount of attention, and this handbook adequately fills the gap in the present-day literature.

In the second edition a chapter on maternity and National Health benefits has been added for the benefit of the Panel practitioner, and somewhat paradoxically a chapter on post-natal care has been included. This is, however, a valuable addition. While the book contains little that is not included in the standard text-books of midwifery, the subject-matter is set out so attractively that it is a pleasure to read. It is a book which can be recommended alike to the student, the post-graduate and the general practitioner.

DISEASES OF THE TONGUE. (Being the third edition of Butlin and Spencer's *Diseases of the Tongue*.) By W. G. SPENCER, M.S., F.R.C.S., and STANFORD CADE, F.R.C.S. (London: H. K. Lewis & Co., 1931.) Pp. xvi + 561. 20 coloured plates and 123 illustrations. Price 35*s*.

Thirty years ago Butlin's book on Diseases of the Tongue stood alone amongst works on this subject. Although the last edition was published in 1900, nevertheless Spencer and Cade, as the preface to the present book tells us, considered that "no better foundation for the work could be found than the work of Henry Butlin."

The detail of the anatomy and physiology of the tongue and its connections which is given in this book is quite unusual, and the completeness with which descriptions of all including the most rare lesions of the tongue are presented is remarkable. As is only to be expected, a very large part of the book is devoted to cancer of the tongue, nevertheless over half of it is concerned with conditions other than malignant. A description of diseases of the salivary glands and thyro-glossal duct is included.

There is an excellent chapter on results of radium treatment. It is based on the results of 253 cases of oral cancer treated by the authors or their colleagues. Radium needles are preferred to seeds. Re-needling of the tongue at the end of seven days in extensive lesions is preferred to the use of larger doses left in for seven days only. The screenage advocated is 0·6 mm. of platinum. The best treatment for cervical glands is very clearly indicated under the three headings of (1) unpalpable glands, (2) palpable glands, (3) inoperable glands.

The bibliographies which are given at the end of each chapter throughout the book should stand as models in length and clearness for all authors on scientific subjects.

We feel that the treatment of many of the conditions other than carcinoma described in this book might very profitably have been given in more detail, and the descriptions of some of the individual cases in less detail.

This book should be read by every surgeon who wishes to keep abreast with the most modern views on all diseases of the tongue and neighbouring organs.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

ANDREWES, C. H., M.D. "The Immunological Relationships of Fowl Tumours with Different Histological Structure." *Journal of Pathology and Bacteriology*, January, 1931.

ARMSTRONG, R. R., M.D., M.R.C.P. "A Simple Method for Deciding Pneumococcal 'Type.'" *British Medical Journal*, February 7th, 1931.

BARNES, E. BROUGHTON, F.R.C.S.(Edin.). "Congenital Deformity and Deafness." *Proceedings of the Royal Society of Medicine*, January, 1931.

CROOK, ERIC A., M.Ch., F.R.C.S. "Branchial Cyst." *Proceedings of the Royal Society of Medicine*, January, 1931.

CUMBERBATCH, ELKIN P., M.A., B.M., B.Ch., D.M.R.E.(Camb.), M.R.C.P. "Old-standing Lupus Vulgaris: Results of Treatment by Fulguration." *Proceedings of the Royal Society of Medicine*, January, 1931.

——— "Uses of Diathermy in Medicine and Surgery." *Lancet*, February 7th, 1931.

ELLIOT, R. H., D.Sc., M.D., F.R.C.S. "Cataract Operation in Extreme Old Age." *British Medical Journal*, January 24th, 1931.

HAMILL, J. M., O.B.E., M.D., D.Sc. "Food as a Preventive of Disease." *Proceedings of the Royal Society of Medicine*, January, 1931.

HANNAN, JOHN H., M.A., M.D., B.Ch. "Further Observations on Ovarian Transplantation." *British Medical Journal*, January 24th, 1931.

HAYNES, F., M.A. "Experimental Dust Inhalation in Guinea-pigs." *Journal of Hygiene*, January 1st, 1931.

HEALD, C. B., C.B.E., M.D., M.R.C.P. "Double Rudimentary Cervical Rib." *Proceedings of the Royal Society of Medicine*, January, 1931.

HERNAMAN-JOHNSON, F., M.D.(Aberd.), D.M.R.E.(Camb.). "The Place of X-Rays in the Treatment of Malignant Disease: With Especial Reference to Cancer of the Breast." *Practitioner*, February, 1931.

LEVITT, W. M., M.B., D.M.R.E. *Deep X-Ray Therapy in Malignant Disease: A Report of an Investigation carried out from 1924–1929, under the Direction of the St. Bartholomew's Hospital Cancer Research Committee.* London: John Murray, 1930.

PYBUS, F. C., M.S., F.R.C.S. (and FAWNS, H. T.). "The Effect of Variations in the Media on the Growth of Normal and Malignant Tissues *in vitro*." *Journal of Pathology and Bacteriology*, January, 1931.

RIDOUT, C. A. S., M.S., F.R.C.S. "Papillomatous Condition of Vocal Cord: Case for Diagnosis." *Proceedings of the Royal Society of Medicine*, January, 1931.

ROBINSON, C. A., B.A., M.B., D.M.R.E. "Cervicitis Treated by Diathermy." *Proceedings of the Royal Society of Medicine*, January, 1931.

SAXBY-WILLIS, F. E., M.D. "Aortic Aneurysm and ? Syphilis of the Lung." *Proceedings of the Royal Society of Medicine*, January, 1931.

SOUTHAM, A. H., M.D., M.Ch.(Oxon.), F.R.C.S. "The Incision for Appendicectomy." *British Medical Journal*, February 14th, 1931.

SPENCER, W. G., M.S., F.R.C.S. (and CADE, STANFORD, F.R.C.S.). *Diseases of the Tongue* (Being the Third Edition of Butlin and Spencer's Diseases of the Tongue). London: H. K. Lewis & Co., 1931.

TWEEDIE, A. R., F.R.C.S. "The Eustachian Tube." *Proceedings of the Royal Society of Medicine*, January, 1931.

WALKER, KENNETH M., O.B.E., F.R.C.S. "The Relief of Retention." *Practitioner*, February, 1931.

EXAMINATIONS, ETC.

University of Cambridge.

The following degrees have been conferred:

M.D.—Sturton, S. D.

M.B., B.Chir.—Oakley, W. G., Taylor, H., Ward, F. H.

Royal College of Physicians.

The following have been admitted *Members:*

Gaafar, M. M., Hancock, P. E. T., Hardwick, S. W., Mitchell, W. E. M.

Royal Colleges of Physicians and Surgeons.

The following Diploma has been conferred:

D.P.M.—Ashby, W. R.

Conjoint Examination Board.

The following have completed the examination for the Diplomas of M.R.C.S., L.R.C.P., and have had the Diplomas conferred upon them:

Adams, F. P., Andreasen, A. T., Baxter, W. S., Churchill, M. H., Climer, A. L., Cohen, P., Cusack, M. K., Dean, D. M., George, W. F. T., Graham-Campbell, R. W., Great Rex, J. B., Hargreaves, W. H., Hobday, F. T. J., Ishmael, D. T., Knight, B. W., McGladdery, W. F., Marshall, S. F., Patrick, F. L. L., Pierre, J. H., Renbom, E. T., Rodgers, H. W., Scott, J. D., Sherman, I., Trueman, R. S.

CHANGES OF ADDRESS.

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PEARSE, R., 711, Medical Arts Buildings, Toronto 5, Canada.

SHORE, T. H. G., 18, The Crescent, Plymouth. (Tel. Plymouth 3224.)

APPOINTMENTS.

MILES, A. A., M.R.C.P., appointed University Demonstrator in Pathology, Cambridge.

SPOONER, E. T. C., M.R.C.S., L.R.C.P., appointed University Demonstrator in Pathology, Cambridge.

BIRTHS.

JEAFFRESON.—On February 20th, 1931, at a nursing home, Northampton, to Jessica, wife of Dr. Dudley Jeaffreson, Blisworth—a son.

MOORE.—On February 20th, 1931, at 3, Wilbraham Place, S.W., to Mary, wife of Sir Alan Moore, Bt.—a son.

SHERRARD.—On February 16th, 1931, at Fairseat, London Road, Beccles, wife of Noël Sherrard, M.R.C.S., L.R.C.P.—a son.

MARRIAGE.

CROOKS—HEATH.—On February 6th, 1931, at the Savoy Chapel, James Crooks, F.R.C.S., to Irene Heath. No guests.

SILVER WEDDING.

HADFIELD—MACDOUGALL.—On St. Valentine's Day, 1906, at St. Bartholomew-the-Great, West Smithfield, by the Rev. Sir Borradaile Savory, Bart., Charles F. Hadfield, M.A., M.D., youngest son of Geo. H. Hadfield, J.P., of Moraston, Ross, Herefordshire, to Wine-Field Elizabeth, youngest daughter of A. W. MacDougall, Barrister-at-Law, of Oakhurst, Westcombe Park. Present address: 47, Queen Anne Street, W. 1.

DEATHS.

FOULERTON.—On February 2nd, 1931, at his residence, 1A, Morpeth Terrace, S.W. 1, Alexander Grant Russell Foulerton, O.B.E., F.R.C.S., L.R.C.P., D.P.H., son of the late Captain Alexander Foulerton, aged 67.

HORNER.—On February 14th, 1931, suddenly, Charles Julian Horner, M.D., of 11, Orford Road, Walthamstow, aged 67.

RUSSELL.—On February 11th, 1931, at The Oaks, Yateley, James Russell, M.D., M.R.C.S., son of the late John Russell, of Dunlewey House, Croydon, aged 79.

SEGUNDO.—On January 31st, 1931, at 39, Howitt Road, N.W. 3, Charles Sempill de Segundo, O.B.E., M.B., B.S.(Lond.).

DE SILVA.—On February 23rd, 1931, in London, Wilton Lionel de Silva, M.D., M.R.C.S, L.R.C.P., B.Ch., of Colombo, Ceylon.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, E.C. 1.*

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